



## Office Policies

We have policies that we feel are important to share with our patients. We strongly believe in our work and professional efforts. Therefore, we ask that you read these policies thoroughly and then sign indicating that you understand these policies and agree to comply with them.

- We believe all treatment begun should be completed. Incomplete treatment almost always leads to problems, complications, misunderstandings, and further disease. Therefore, if a plan is agreed upon and started, it needs to be completed.
- An appointment in our schedule is a bond of trust that we will be here to serve you, and you will be present for treatment. Our office policy is firm in this regard, and we will not tolerate frequent cancellations or constant short-notice changes. Your signature below indicates that we must have mutual respect for each others' time.
- We believe we have a responsibility to use the best professional care, skill and judgment in planning and delivering your dental treatment. Your payment will reimburse us for our services. By signing below, you are indicating that you agree, after all fees have been fully explained to you, that you will fulfill your financial commitment to our office promptly and completely.
- Full payment is expected at the time of service unless other arrangements are made. A service charge of 2.0% per month will be on the unpaid balance along with a \$2.50 charge per billing statement.
- Return checks are subject to a \$35.00 service charge and will terminate your privilege to pay by check on future visits.
- It is understood and agreed that in the event any outstanding balance has to be referred to a collection agency or attorney for recovery, you will be fully responsible for all collection agency and attorney's fees.

## Authorization

I understand that I am responsible for all costs of dental treatment. I hereby authorize Calm Lake Dental to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.

The information on the Medical History is correct to the best of my knowledge.

\_\_\_\_\_  
Responsible Party's Signature

\_\_\_\_\_  
Date